

**OLYMPIA PEDIATRICS
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

Our **Notice of Privacy Practices** describes how the protected health information of our patients may be used and disclosed, and how that information can be accessed. If you have questions about this notice, want more information or want to see a record, contact the Olympia Pediatrics Privacy Officer. This form will be retained in the medical records of the patient(s) indicated below.

By my signature below I acknowledge receipt of the Notice of Privacy Practices given to me by a representative of Olympia Pediatrics.

Print Patient name(s)

Signature of parent or legal guardian

Indicate Relationship to minor child(ren)

Printed name of parent or legal guardian

Date

I am declining to sign. _____

Signature of parent or legal guardian

Date

CLINICAL INFORMATION CALLS

We will communicate with you regarding upcoming appointment confirmation and clinical information (such as test results and treatment plans). If we are unable to reach you at home may we:

- Call you at work**
- Leave a message on the answering machine**
- Other** _____

Signature

Date

(Notation, if any, by Staff)